NAVPERSCOM NON-APPROPRIATED FUND GROUP BENEFITS ENROLLMENT FORM

SUPPORTING DIRECTIVE BUPERSINST 5300.10A

PRIVACY ACT STATEMENT: SECTION 5 OF THE UNITED STATES CODE 552A(B), AUTHORIZES COLLECTION OF THIS INFORMATION. THE INFORMATIONYOU SUPPLY WILL BE USED TO MANAGE AND ADMINISTER BENEFIT PROGRAMS FOR NON-APPROPRIATED FUND (NAF) DEPARTMENT OF THE NAVY PERSONNEL. COLLECTION OF THIS INFORMATION IS AUTHORIZED BY EXECUTIVE ORDER 9397 AND 5 U.S.C. SECTION 301. FURNISHING THE INFORMATION THIS FORM, INCLUDING YOUR SOCIAL SECURITY NUMBER AND OTHER PERSONAL INFORMATION, IS VOLUNTARY. HOWEVER, FAILURE TO PROVIDE THE INFORMATION MAY DELAY OR PREVENT ADMINISTRATION OF BENEFIT FUNCTIONS.

NAME:	SSN:	☐ MALE ☐ FEMALE
STREET ADDRESS:	CITY, STATE, ZIP:	
ACTIVITY NAME AND LOCATION:		
DATE OF BIRTH: (MM/DD/YYYY)	DATE EMPLOYED: (MM/DD/YYYY)	

MARITAL STATUS:
☐ SINGLE OR LEGALLY SEPARATED ☐ MARRIED ☐ DIVORCED

INSTRUCTIONS: THE FOLLOWING SHALL BE COMPLETED AND ATTACHED TO THIS FORM FOR ALL INITIAL ENROLLMENTS OR CHANGES EVEN IF ONLY ONE PLAN IS INVOLVED.

1. ALL PARTS OF THIS FORM SHALL BE COMPLETED FOR INITIAL ENROLLMENT
2. A SPECIFIC MEDICAL PLAN ENROLLMENT FORM IF THE CHANGE INVOLVES A MEDICAL PLAN CHANGE.
3. A COMPLETE BENEFICIARY DESIGNATION FORM

A. TYPE OF ENROLLMENT
This is a new enrollment. NEW HIRE ____ STATUS CHANGE TO REGULAR ____ REEMPLOYED____
This is a change in coverage election during open season. ____
This is a change in coverage due to a change in family status. ____
This is a termination or waiver of enrollment. ____

B. MEDICAL PLAN ELECTION
I ELECT DOD Uniform Health Plan ____ HMO (WHERE AVAILABLE) ____
I ELECT to cover Self Only ____ Myself and 1 Dependent ____ Family_____
I DECLINE ALL Medical Coverage ____
I ELECT to terminate all current medical plan coverage ____

C. DENTAL PLAN ELECTION
I am enrolled in a medical plan and also want to enroll in the Dental Plan ____
I DECLINE ALL Dental Plan coverage ____
I ELECT to terminate my current dental plan coverage ____

D. LIFE INSURANCE ELECTION
I Elect Basic Coverage: ____ Option A (1 times pay) ____Option B (2 times pay)____
I DECLINE Basic: ____ Option A ____ Option B ____ All Life Insurance Coverage ____
I ELECT to terminate: Basic ____ Option A ____ Option B ____
____All life insurance coverage

E. DISABILITY PLAN ELECTION
I ELECT to enroll in the Disability Plan ____
I DECLINE Disability Plan coverage ____

F. RETIREMENT PLAN
I ELECT to enroll in the retirement plan with deductions starting the pay period after

I have one year of regular service. ____.
I WAIVE retirement plan coverage and understand that I can join at any time without

prior credited service. ____
I ELECT to discontinue participation in the retirement plan. I understand that I will

Not receive credited service or any periods of discontinuance. ____

EMPLOYEE'S SIGNATURE:	DATE:

CLEAR FORM

NAVPERSCOM NON-APPROPRIATED FUND GROUP BENEFITS ENROLLMENT FORM CONTINUATION.

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G. 401 (K) SAVINGS AND INVESTMENT PLAN ELECTION
I ELECT to have a before tax contribution each pay period of ____ percent. My Investment selections are identified on the attached Vendor form.
I am currently participating and wish to change my before tax contribution to ____%.
I DECLINE to participate in the 401(K) plan. ____
I ELECT to terminate current participation. ____

H. I HERBY AUTHORIZE DEDUCTIONS FROM MY EARNINGS TO PAY THE PREMIUMS for the above elections. IF I DO NOT HAVE ENOUGH EARNINGS DURING ANY PAY PERIOD OR GO INTO A NONPAY STATUS I WILL PAY THE PREMIUMS DIRECT TO MY SERVICING PERSONNEL OFFICE NOT LATER THAN THE FOLLOWING PAY DAY. COVERAGE FOR MEDICAL, DENTAL, LIFE INSURANCE AND DISABILITY INSURANCE COVERAGE START THE DAY THE ENROLLMENT FORM IS SIGNED AND RECEIVED IN THE PERSONNEL OFFICE. A FULL PAY PERIOD OF PREMIUMS WILL BE DEDUCTED THAT SAME PAY PERIOD. I HEREBY CERTIFY THAT ALL STATEMENTS MADE ON THIS FORM ARE TRUE TO THE BEST OF MY KNOWLEDGE

I. WITNESSES. THIS FORM IS VALID ONLY IF WITNESSED BY TWO PERSONS. THE WITNESSES MUST BE AGE 21 OR OLDER. (A WITNESS IS NOT ELIGIBLE TO RECEIVE PAYMENT AS A BENEFICIARY). WE THE UNDERSIGNED CERTIFY THAT THIS STATEMENT WAS SIGNED IN OUR PRESENCE.

WITNESSES' SIGNATURE	STREET ADDRESS	CITY, STATE, ZIP	DATE

J. I UNDERSTAND THAT AS A REGULAR NAF EMPLOYEE I MUST MAKE AN ELECTION TO ENROLL OR TO WAIVE ENROLLMENT DURING MY FIRST 31 DAYS OF EMPLOYMENT AS A REGULAR EMPLOYEE OR WAIT FOR AN OPEN SEASON. ENROLLMENTS DURING OPEN SEASONS FOR LIFE INSUPANCE AND DISABILITY INSUPANCE WILL REQUIRE PROOF OF INSURABILITY. (ENROLLMENT BEQUIRES COMPLETION OF THIS FORM AND DELIVERY TO THE PERSONNEL OFFICE WITHIN 31 DAYS OF MY HIRE DATE). I ALSO UNDERSTAND THAT

1. TERMINATION OR CHANGES OF MEDICAL AND DENTAL PLAN COVERAGE CAN BE DONE ONLY DURING OPEN SEASON.
2. I MUST BE ENROLLED IN MEDICAL PLAN BEFORE I CAN ENROLL IN DENTAL COVERAGE.
3. IN ORDER TO ENROLL IN OPTIONAL LIFE I MUST BE ENROLLED IN BASIC LIFE.
4. DISABILITY PLAN COVERAGE SHALL NOT BE TERMINATED ONCE ENROLLMENT BEGINS.
5. MY 401(K) CONTRIBUTION CANNOT EXCEED THE IRS MAXIMUM FOR THE YEAR.
6. THE EMPLOYER MATCH IS BASED ON THE PERCENT CONTRIBUTED EACH PAY PERIOD AND IS ONE (1)PERCENT FOR EACH PERCENT CONTRIBUTED UP TO A MAXIMUM OF 3 PERCENT.
7. IF I TERMINATE DEDUCTIONS TO THE 401(K) PLAN I HAVE TO WAIT UNTIL THE NEXT OPEN SEASON AFTER 6 MONTHS HAS PASSED TO REENROLL.
8. IF I AM OVER AGE 50 I MAY MAKE ADDITIONAL CONTRIBUTIONS TO THE 401(K) PLAN.
9. THE (401K) IS A SAVINGS PLAN AND THE ONLY REASON I CAN WITHDRAW MY MONEY BEFORE AGE 59 1/2 IS FOR HARDSHIP REASONS AS DEFINED BY IRS.
10. I CAN CHANGE MY INVESTMENT OPTIONS BY CONTACTING THE 401(K) THIRD PARTY ADMINISTRATOR. I CAN CHANGE MY PARTICIPATION AMOUNT AND ELECTION TO JOIN ON JANUARY 1, APRIL 1, OR OCTOBER 1..
11. I HAVE INCLUDED ALL THE NECESSARY INFORMATION ON THIS FORM. INCOMPLETE DATA MAY DELAY YOUR COVERAGE. THE INFORMATION ON THIS FORM IS NEEDED TO DETERMINE ELIGIBILITY, BENEFIT COVERAGE AND THE COST OF THAT COVERAGE. LAW PROHIBITS ANY OTHER USE OF THIS INFORMATION.
12. I UNDERSTAND AND ACCEPT THE TERMS OF THE LISTED PLANS AS THEY AFFECT THE ELECTIONS I HAVE MADE ON THIS FORM.

EMPLOYEE'S SIGNATURE:	DATE:

CLEAR FORM

I HAVE REVIEWED THE DESIGNATION AND CERTIFY THAT THE FORM IS COMPLETED PROPERLY.	
DATE RECEIVED IN PERSONNEL:	PERSONNEL SIGNATURE:
ACTIVITY FUND NUMBER:	DATE PASSED TO PAYROLL:

CLEAR FORM